Hunger Tolerance and Weight Loss

This comes down to this idea that some people are really hunger tolerant and some people are not. So, there are some people who I just don't find hunger peaceful and distressing, and they're very sensitive to changes in levels of leptin.

So a slight drop in their level of left in and they will experience hunger that is difficult. It's difficult for them to think about anything else. And for those people losing weight is really hard.

Any caloric deficit that they try, any restriction that they try will be met with pain and suffering. And so weight loss in that context is much harder than for someone who is like more hunger tolerant.

They just they don't feel it as intensely emotionally, cognitively, physically. They just they're just not it's just not that hard for them. Welcome to Doctor Talks, the podcast where every episode leads to a healthier you.

Join us as we navigate the world of optimal health, uncovering groundbreaking strategies to conquer chronic disease. In each episode, we'll bring you the latest insights from leading health experts, medical innovators, and wellness warriors.

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Podcast Introduction and Guest Welcome

All right guys, I'm so excited for us to have this episode today of the real integrative medicine podcast. I am joined by one of my friends colleagues, Doctor Ashley White, and I think that this is going to be one of those conversations that becomes like this monumental, like landmark podcast episode.

We're talking about appetite. We're talking about weight management. We're talking about medication kind of answering all of the analyst questions about this, conversation.

I'm so excited that you're here with me today. Ashley. I just think you're so brilliant and have so much to share. And I'm so happy to share the mic with you today.

Thank you. I'm very, very humbled to be here as well. This is a big deal. Thank you. So Ashley and I actually go like pretty far back. So which if you are connected, with me on social media, I don't encourage that you follow Ashley as well.

We, have actually just started working together, like, in a more like, sort of clinical sense where Ashley is joining my practice, in Ontario, Canada.

But we actually made history that, like, stems back. I don't always a 20 years at this point, Ashley, where ever period of time spent time on an emergency response team together at university and where we, like, slept in bunk beds or responded to all of the, medical emergencies on campus.

And after that point in our lives, separated. And it doesn't you didn't, you know, hear from each other, even know what we each other were doing for for so long and got reconnected, this past summer, which has just been like, an

absolute joy for me because you're such like, God like, high level leading woman that I admire.

And so I'm so excited that we spread to spend so much time together now. Yeah. Same thing. It's not, it feels a bit a bit like destiny. So I'm very I'm very happy that we were able to cross paths again.

For sure. It was because of a Facebook ad, but you're very good at it, so well done. I was looking because that Facebook ad. That's right, I target markets.

Are we Ashley. Yeah. I was like, wait, is that Jordan? What's happening here? And then I was like, there's a whole world out there. I didn't know, I had no idea.

And so in our time apart, which was many, many years, you had, a pretty like, interesting journey to get to this point where you are in your career now, which we know will save 90% of that back story for another day.

But the part I want to hear about is how you got so interested in obesity medicine, appetite, literacy. And you know what we're kind of coining as like metabolic strategy with patients.

Yeah. How that how did you get so interested in this and how did that spark this passion for you. For this to be the way you're going to change the world?

Ashley Whiteu2019s Path to Obesity Medicine

I'm not exactly sure why, but I started reading diet books when I was really young. So like ten, 11, 12, I started actually learning about sometimes they were just straight out diet books, but sometimes they were like nutrition science and nutrition physiology books.

I'd always, always been interested in food as fuel, and also interested in sports performance. I was it was sports a really important to me for a long time, and always identified my body as a bit different than others, because I was in a larger body, especially as a teenager.

And so I was always trying to figure out, like the system back. And, you know, anytime I had an opportunity to learn about nutrition or health or food, I, I took it even prior to several other things happening in my life that we can talk about another time.

So that's always been both an inherent curiosity and also, I think, a reflection of the fact that I was raised in a family of some really large people who struggled a lot with their with their weight and weight struggles were part of the everyday conversations in my life, for a very long time.

And, I, found myself later studying addiction and public health and, also working in policy around public health and obesity was actually almost started a PhD on obesity, and social networks then.

And that would have been in epidemiology. And I didn't end up doing that. But obesity is one of those things that we used to talk about in public health has a wicked problem, which means, everything matters and no one's in charge.

And it felt really difficult and futile. And then fast forward to my first several years of practice, realizing that I carried for a lot of people who had a lot of metabolic disease, and telling them to lose weight based on what I knew was just a terrible idea.

But it's it's really what I was told to do in my learning. And, and there the line that got me here is not straight at all. But here I am doing what feels like, a full, robust version of of the work I was meant to do, for sure.

I love that, and I it's so common that people have just this kind of, like, personal story, with their or whatever it is that their passion, is in medicine when like it sounds like.

And I would love to kind of hear it just a little bit more about like, was there like a particular. Like you were working like family medicine in a small town, like, was there a particular moment where you were like, I need to be the person who could change this, how this is done?

Like, how did you, like, get to that point? Yeah. So I had I was a patient, I after my first child, my daughter was a little over one, and, I was working far, far too much, and my weight was going up and up and up.

And I had previously managed my weight, West movement and west portion and just being younger, and, you know, and certainly at some sometimes I manage my weight in ways that I would not advise a patient to do.

But but I, I enrolled in a medical weight management program early, early in 2021. And I was treated like, like I was a person who was obviously experiencing appetite dysregulation.

And I was obviously experiencing a clash between the needs of my brain and body and the world I had constructed for myself, which was a high pressure rural average.

I was were a rural family and rural emerged, and I was working a lot and I was postpartum and I could not regulate my appetite. And I was working a lot of shift work, missing a lot of sleep and and really struggling to figure out what, what my body was doing.

And I was at my highest adult weight. And so I was treated appropriately. Like, not not completely. I would say there's, there's things that could have been done better, but I had this moment of relief from the constant, dysregulation, the constant, conversation with my appetite that was constantly asking me to soothe myself with some food or avoid something uncomfortable with food.

And I had my experience really, for the first time ever, and through a combination of medication and, and therapy. And I thought, well, this is just the beginning.

I knew instantly, I knew instantly the minute I woke up as though I was into someone else's brain, I was like, this is just the beginning. There's way more to this story.

And since then, I have experienced the world in a lot of different bodies, and I has. I experienced feedback from the world in all sorts of different bodies.

And I, I have run the gamut of of the kinds of people, kinds of things people experience. And in larger bodies, there's a lot more to know than just you need to go on a medication that's going to quiet the noise, did a lot more to understand.

If you're going to do lifelong weight and appetite regulation well in a way that serves your goals and your purpose. So that's when I first started to say, okay, well, I need to reverse engineer.

I really I need to reverse engineer the process by which allowing allowing people appetite regulation such that they can then go and accomplish bigger things and improve their health in the following ways.

That's when I know. Do you know what I was dying for? When I was a practicing clinician, I wanted someone to summarize the latest research, tie it up with a nice little bow, and deliver it to my inbox every single month.

Personal Weight Struggles and Appetite Dysregulation

And doctor Jordan Robertson and the host of The Real Integrative Medicine podcast, and this episode is brought to you by my free integrative medicine magazine called The Stacks.

We're all dying for unbiased and industry funded information to help us be the best in practice. The stacks delivers you quality articles every single month on the latest research on things you care about in practice, as well as opinion articles and business advice for integrative practitioners and naturopathic doctors.

You can subscribe to the stacks with the link in the show notes today, and get access immediately to all of our back issues that show you exactly how to be a Evidence-Based practitioner.

I hope you sign up and you'll enjoy it. You said such important things there that I just want to backtrack on because, you know, sorry. You're like, no, but this is such as I'm more I'm just saying it a second time for a listener that you're talking about your life, right?

Like the shift work, the postpartum, the overworking, the high stress and that that, you know, became part of the dysregulation with respect to appetite.

And it's so common that I'm going to say especially women, but lots of people, but especially women would normalize. So many of those aspects of their life and then feel like they needed to white knuckle their waist through appetite regulation.

Right. That like that was this like, morale issue that they had where they couldn't being good enough, you know, with respect to appetite. But you painted this beautiful picture where there was a.

Yeah, that of course that would be really difficult and made that connection with your appetite, like most people I don't think would be able to do that.

The how their environment was becoming part of the stage like that, which like their appetite was difficult to to manage it. Yeah. And I'm lucky because there have been times in my life where I have felt more regulated than others, and so maybe I was just more sensitive to it.

But also, I have since come to understand that I have a genetic variant. That means that I'm exquisitely sensitive. So once I started, once I opened the lid of all of this, you do get down to the DNA at some point, and I had a very powerful response to, pharmacotherapy.

I got a medication intervention that I was so obvious, it was like it was like a horizon lifting. It was like blinders had been taken off. So I had a dramatic response that maybe I was a bit more sensitive to because of my works than other people.

But but this goes to show you how how complex it is, because lots of people start weight loss medication. They notice nothing at all. And I think that right now we are we are at the beginning of understanding what what we're how to help people with lost weight.

And it's actually not how to help them with weight. And what I find is like, there's this weight story which brings people in the door and starts the conversation.

And then under that, there's an metabolic story, which is actually usually pretty messy, entangled, and then under that, there's the story that we've been telling ourselves about that metabolic story. And usually it's a story of willpower.

Like you've said, usually it's a story of I just haven't worked hard enough. I just haven't understood. I just have a slow metabolism. It's my thyroid, yada yada, yada, yada.

And that maybe. But but most likely it's not willpower and it's not your thyroid. Most likely it's a combination of a bunch of things on top of a genome that may or may not be very supportive of weight regulation, on top of an environment in a culture where we have an we have a food environment that is engineered for your excitement and it one person's willpower cannot stand up to that.

We have billions of dollars in food marketing that are trying to get you to use food to solve all of your problems, and it can't. I restricted by the way, I know I shy it.

I tried with a carrot cake that my mom got, I think for my birthday a couple of weeks ago. It's like it's I didn't. Yeah,

yeah, the bottom of that pan didn't have all the answers.

I do, I have all the answers. Yeah, yeah, I don't, but I think, like, you know, for you to call it out and again, that piece around like your environment and the influence that I want to talk about the like environment side.

And then there's like the genetic side because I think both of those pieces we've not put enough emphasis on. And so and then it does come back to like, well, who are we blaming if right like or where it is the blame fall.

And for some reason and we're always looking for someone or something to blame. But that like environment piece like we could say to patients, you know, if you're not sleeping you're going to your appetite drive will be higher the following day.

And it's it was always so interesting to me in clinic how easy that was to brush off. Right. Like patients would be like, yeah, okay. Right. But like I should still be able to I should like and I should still be able to manage it even if I didn't sleep well.

And I'm like, you're all like weaning literally nobody you don't like. You literally can't. If we if you don't sleep, you will eat 300 extra calories tomorrow.

Like we just know it. And yet that still was something so difficult for people to accept the and if their food environment, or even like their family structure meant that other people were being involved or influencing that food environment, you know, like, oh, I should be able to sit beside my partner while they eat Doritos and I'm not going to eat anything.

And we're like, no, no, no, that literally eventually doesn't work. But it does require it's far too much energy and effort so much. And I ask this, what happens if we can put some of that down, right.

Like if we can put some of that like, you know, trying to push a boulder up a hill, feeling, whether that's through medication or changing the food environment.

But it's so easy to change people's food environment. I don't think after years and years of trying to coach people through it, it's not like people just needed to clean out their pantry.

And then they would suddenly find success, you know, and I, I think I was ahead of the game in that I had dieted so much and I had done every single like I was a raw food host for a while.

I like I have done everything the zone friggin all the time. And so I knew very well that it was on an information deficit that, whatever I did in the round of weight loss, even back before I, when I was sort of a more typical family doctor, it was never just like, oh, just do this because I was like, I know very well that that does not work.

And I know very well because that's my life. And I grew up in it. So, so the food environment is not simple to, to modify. And then, you know, we can talk about the, the ecosystem of this family home, but we can talk about the ecosystem of the neighborhood or the policy ecosystem that, talks that governs food additives and endocrine disruptors.

Like, we can talk at every level, which is why obesity is so tricky. And it's linked also to, you know, the way that other health issues manifest in terms of autoimmune disorders and inflammation and metabolic like, it's all related.

But at the quest, at the core of it is there's a bunch of things that make it really easy to gain weight and are only a few things that make it possible to lose and sustain the loss of weight.

Genetics, Environment, and Appetite Regulation

And we are all a little bit uphill. And after working shift work and working far too much with ADHD that was undiagnosed and unmanaged and a genetic propensity for appetite dysregulation, obesity, I just I think that I and

there was a time when I thought, oh, this is just me.

This is just all of my inner faults being revealed. And but I realize actually know that doing that for over a decade actually changed me. It changed how I experience joy.

It changed how I experience everything. And there is now. And the reason I'm doing this work is because I do want to give women in particular permission to say, oh, in order to solve the weight problem, I actually need to solve a lot of other problems, and they have to deal with the stories I tell myself in the stories that other people around me are telling me, and they also have to do it, how my body turns food into fuel and how it slices of that fuel.

And actually all of that matters. And that sounds extremely complex. It's actually not you, but it requires a strategy, which is where this idea of a metabolic strategy has come from, because that's actually what I do.

It's and that's what I think people fundamentally need. They don't need just like a script for GLP one receptor agonist, they need a strategy that that reflects their own individual variables.

Personally. Yeah. Can we talk a little bit more about just that genetic piece there? Because I think and this was something that when I, when you and I started working together, that I really hadn't spent a lot of time on myself.

I've like when something's new to me, then so talking a little bit about, like, that genetic variation, like when we talk about obesity being genetic, like what part of it is the genetic part?

And like, how does that play into what we now understand about appetite regulation? Yeah. So the the really black and white answer is that there are several monogenic obesity syndromes.

So these are obesity. I was like for that title syndrome which is a like the most common of the very rare times C deficiency. There's leptin deficiency.

These are things that are usually autosomal recessive genes, disorders that that show up. And they cause market hyperplasia as early as H2. And they cause high weights as well as well as a number of other, anomalies like, you know, depending on exactly what, what the disease is.

And so some of my patients have those, and, and they are market cases now that a small number of people. Then there's this, the rest of us saw which a few genes turned on, either in a, in a inherited pattern or an epigenetic pattern or a spontaneous pattern.

All, all in all together determine body size, height, width, bone mass. Determined all sorts of things that help regulate body size and metabolism and appetite.

So we have this sort of stew of genes that we think contribute to the ultimate size, that a person is going to end up being now in a caloric and a calorically restricted environment where, you know, our populations have face famine and food insecurity.

Obesity is not the supply of that, whereas we are now in a modern food environment that reflects a very short period of time relative to like the length of human history.

And those genes are now clashing with the fact that there is a caloric surplus everywhere we turn. Yeah, everywhere. Every gas station is a caloric surplus.

And it isn't to say that calories are bad, but if we take a like, how do I fuel myself for the life I want to live mindset, it's like, oh my gosh, of course my genes want me to gain weight because that means they're hearty and good, and I have the ability to accumulate weight, and I have the ability to accumulate fuel and store it for another day, which is marvelous.

Marvelous. Except for now, where we have too much. Is it? So that's a genetic piece down. Yeah. Sorry. No, I was

going to say. And then just to, like, follow that, that that through line there around appetite like, like what I've heard you say and what I think is really valid and, and important to, to share is like that.

It's not a like on off switch with some of those genes there. I say like there is a spectrum for how those things are experienced. And that's why we're maybe needing to have this more individualized conversation.

About how we manage these patients or how we manage ourselves, because, you know, the way that our body and brain are going to show up in this, you know, high calorie environment is different than somebody else's.

And that that's that has nothing to do with our emotions or our willpower and has a lot to do with how things are wired. Yeah. And this comes down to this idea that some people are really hunger tolerant and some people are not.

So, there are some people who I just don't find hunger peaceful and distressing, and they're very sensitive to changes in levels of leptin. So a slight drop in their level of left in and they will experience hunger that it's difficult.

It's difficult for them to think about anything else. And for those people losing weight, it's really hard. Any caloric deficit that they try, any restriction that they try will be met with pain and suffering.

And so weight loss in that context is much harder than for someone who is like more hungry or tolerant. They just they don't feel it as intensely, emotionally, cognitively, physically.

They just they're just not it's just not as hard for them. So they can sustain a caloric deficit for a little bit longer and usually have more success with, with weight loss.

Just through the dieting approach, even that has its end because caloric restrictions are hard to maintain for a long period of time. But those genetic variables explain why we see some people who, like, just don't tolerate diets.

Yeah. And how does how does emotional executive fit into this. Right. And and because, I mean, there's lots of spectrum around like emotional eating and there's even like diagnoses that are, you know, trying to capture some of those emotional eating, definitions.

How does that fit into this conversation or does it. So emotions are one of the ways that our appetite manifests itself, either with irritability or just like if you think about someone who's becoming hypoglycemic, they can look a lot of different ways.

They have physical manifestations, they may sit, they may sound confused, they may say words that don't make sense, and then they also may look panicked.

They may have emotional, I mean, emotional story that is being told, the hypoglycemia. So similarly, the human appetite has an emotional expression, the human appetites also in the deep brain, it's in the primitive brain, which is where most emotions are.

You know, and originate, I guess, is exactly the right word. But our, our emotional life, the emotional experience that we have is, is a primitive when it comes.

It does not come from the prefrontal cortex. Our prefrontal cortex is how we can modulate and regulate emotions, just like that's how we we do that for our appetite.

So if we think about the appetite as an expression of the function of our deep and primitive brain, sometimes we can be a bit more kind and gentle to, to our, to ourselves because it's like, oh, I'm just an animal.

Yeah. But we also can realize that, when we, you know, most of the time emotional eating is attributed to something that women do. And so there is a bit of a feminist lens there that.

Oh, it's just if you weren't so emotional, if you weren't so weak, if you weren't, if you didn't have, all of these emotions, then you wouldn't have a weight problem because you wouldn't eat in response to sadness.

And I think that that's a we do a great disservice to people by a saying that emotions are a problematic because they're not, and be attributing something that we don't like, we don't know.

So when someone has a binge or, or an emotional eating episode, we don't know their physiologic state. I don't know if they are tired. I don't know if they're hungry.

I don't know anything about that time, unless we're tracking. And what I've come to see in my practice is that whatever binge eating disorder is diagnosed in someone with PCOS, magically metformin tends to make it go away.

Which really makes me wonder, is that, an appropriate diagnosis because metformin, does it treat emotions? It is not a psychotherapeutic agent. As far as I'm aware.

Unless someone has magic, information I don't have. So why are we call? Why are we diagnosing binge eating disorder and someone who's physiologic state we actually haven't captured at the time of the binge?

And the disorder is a real thing. I don't want to. It is a real thing. And if we're diagnosing binge eating disorder, but that not at least exploring whether there is some sort of insulin dysregulation or in disorder of glucose homeostasis in that person, as there would be in someone who has class.

Then why or why are we just carrying about a small part of that overall picture? We're carrying about a really small part of that person's metabolism.

And binge disorder is sometimes treated with atypical. And it psychotics, which is going to double down on the weight gain. Right? So that isn't so frustrating to me.

That and so in my practice, in my in my work, like the the program that I offer, I just call it big eating all all eating that feels like it's eating past hunger and into wanting if if you're if you're aware of physiologic fullness and you're still eating, we just call it big eating.

Doesn't matter what I don't care doesn't matter what it is. And then it demoralizes it. It neutralizes the like good, bad. And it just says, yeah, this is actually part of being human.

Lots of certain people eat into fullness. Lots of large people don't eat into fullness. Is a deeply, deeply personal experience. And I think we're missing there the the big picture here.

So let's take shift for a second. Talk about, the medication options. And I'm, I'm curious, you know, the there's been like a rapid adoption of medication, which I'm actually, like, in favor of lots of this.

And I think that I talked about it before on the podcast felt, revolutionary.

Emotional Eating and Metabolic Context

It's been in for some of my patients, too. I always called it, like putting down the backpack that they'd been carrying around their entire life. And in that backpack was a heck of a lot of, behaviors that they needed to do to avoid gaining weight, or to try and lose weight, like food weighing and all of these things.

But then also the entire lifetime of stories that they had, about how their willpower or their lack of motivation was the cause. And I always thought that, like, it was such a almost like a grief experience for patients to go on medication because they realized, like, very quickly, it's all similar to your story, realized very quickly that, like, they could put down this entire story that involved their swim coach and their grandmother and all of these people who'd ever told them about their their weight and that they they actually, I acknowledged, I hope for most of them that there was so

much of this that was like part of their their makeup and not part of their, their willpower.

But just like I think people like, loosely know how those medications work. But I'm curious in the context of our conversation that we're having now, how do these fit in this?

Conversation? Yeah. So the the guideline based answer is that there are four pillars of, of weight treatment, obesity treatments. There's medical nutrition therapy which is not restriction.

It says like if you're going to maintain a caloric deficit, how do you do it in a way that's healthy. There's surgery, there's behavioral interventions also known as CBT or psychotherapy or any you know, I like coaching in that in that color.

And then there's medication. So it's one of four right. And for some people surgery surgery it's a for some people all for is what's needed. Right. But the medication pillar is taking the world by storm because it opens up, treatment to a lot more people who otherwise wouldn't be a candidate for bariatric surgery or simply don't want it.

And it's it's far less invasive, than, than bariatric surgery. So that's useful. So the in the currently available medications in, in Canada fall into three categories.

One is is a medication that simply prevents the absorption of fat. It's also known as orlistat. It is not widely prescribed nor used. And it results in some micronutrient deficiencies.

And it just is there for some people. Then there's the the category that I think will also expand at some point, at least the category that targets the, Mylanta curtains for receptor in the brain, which is a combination of B propionate and naltrexone, also known as country if by brand.

It's a standalone drug in the category of medication that help with appetite regulation, and also LDL lowering, blood pressure lowering, insulin resistance lowering and these help with people who have a lot of wanting based eating.

And I use that I, I you pull from all the categories. When I use my treat. And I often have people on mixed treatment, especially because my goal, my, my therapeutic goal is to keep people on the lowest effective dose as low as possible.

So pulling from multiple categories can help you do that. And then the other, the largely well-known category of medication are the hormone. All, medications that help with the influence influence the appetite both centrally so in the brain, but then also at the level.

And it helps with I talk about like tightening the connection between the brain and the gut. And it essentially allows the gut and the brain to hear each other more closely and to experience satiety a little bit more easily and to but less effort into, managing wanting and the desire for food.

So this category of medication includes GLP one receptor agonist like, liraglutide, also known as extend. Semaglutide, also known as Doc's ozempic and we govi.

And now towards appetite which is both a GLP one receptor agonist and a gap and it's true that the tide also known as Majuro and in the, in the US it's also known as that found.

And so this category of medication is all about improving the connection between what we call that the pituitary, and got access and the, the way that it does that is, you know, we sort of understand how this works.

And we, we see that it works. And there's certainly the gut slows down. So there's like this mechanical I can better perceive the fullness in my stomach because my gut is moving more slowly.

But the benefits go beyond that. And if we, you know, some people are like, oh, this medication only works because I'm nauseous or I want to vomit or blah, blah, blah.

It's like it doesn't actually matter the extent of your side effects, even if you're a person who experiences none of that, you kind of lose the same amount of weight as the people who have early nausea and vomiting.

So it's it's actually not from a mechanical obstruction. And the cases of gastroparesis, which are reported on a lot on social media, are not nearly as influential.

And like if you ask the people who actually practice these medications like these are these are not common or even as bad as they're made out to be on social media.

So there's that. So the role as I've overall of weight loss medications is as an adjunct to getting the story straight on, like, why are you why your appetite is the way it is, right?

So I can give someone a medication, but it won't solve their sleep debt that, I mean, if it helps them lose a little bit of weight and helps improve oxygenation and ventilation at night.

Yeah that's great. Super. That's awesome. They they may still need their sleep apnea treated. They still may need to work fewer shifts at night. Like they still may need all of those things.

Weight Loss Medications and GLP-1s

So the GLP one receptor agonist well will help I think about it is like, it can depressurize the metabolic system. It can take some, some steam out of the, the canister.

But it it doesn't solve the root problems. And there are like really important like there are there are like, you know, top five scientific discoveries of the past 20 years.

I would say agree that, yeah. It's interesting, as you were describing the other three options, I was like, oh, well, like this, this options like it has an economy of scale that we've never, been able to manage with how many people are suffering.

We've never like, we would never be able to scale any of the other three options aside from maybe like group based CBT, but again, or the scale that we're trying it that we'd love to be able to talk about here is the like million in the millions.

And you're right, now that you're right, Chile don't have that ability. And it's so you know, it's interesting because I think that this is maybe why it's such, interesting and why the adoption was so rapid.

Like if we had a 1 to 1 ratio of CBT therapists and people who, had obesity, maybe we'd have an economy of scale that and then maybe we'd be like, oh my God, there's widespread adoption of CBT for obesity really needs to be questioned.

But really we cannot. Yeah, yeah. You're right. You're totally right. It's a little yeah. It's a absolutely yeah. If we raised this like question about like how rapid this has made it to market, we don't have that opportunity with anything else.

So I find that really fascinating. And where I like my interest lies with this. And we actually just talked about this with our confident clinicians is like that.

The rapid adoption means that now we're going to have to like tie up some loose ends in medicine. And. Right, I think we have in life prescriptions and lots of people having I'm going to say in air quotes success.

I think we have to be careful with that word because success to me probably just came at that does to you where we have a, person with positive body, acceptance and has improved their food environment and is sleeping through the night and like and and and and and they lost weight to me that success where you know, but we've maybe have widespread weight loss we'll say with the widespread adoption of prescriptions.

But there's some loose ends I think that maybe need to be tied up now or we're going to, become aware of these loose ends over the next 5 or 10 years.

Like, I have some suspicions on what I think that conversation is going to look like. But I want to hear what you think. Yeah. And this is where my my career as an emergency physician, I think it's really illuminating some concerns that I have, around long standing use of GLP one receptor agonist.

Without thought about balance. Like, I think if we were to take this idea that the point of GLP one receptor agonist medication is to restore appetite balance, and in fact, all the weight loss is about restoring balance.

So restoring sleep debt, restoring micronutrient deficiencies and restoring, iron deficiency. Is this like big untreated monster in in women's health?

I think if we were to help with the perimenopausal, challenges that women face, if we were to help and think of GLP ones as one tool in our arsenal of balance right then I think we would be very attentive to bone density changes, that come with long standing caloric restriction and, and, and under nourishing under fueling.

And we would be really attentive to the role of sarcopenia or low, no muscle mass relative to size. And no muscle function. We would be very attentive to those things.

But because we live in a society where thin is best and that paradigm reigns, even among, especially among health care providers, that you're all good because you're thin.

We then don't think about it in terms of ballots. We we missed that completely. The conversation is just about getting thinner. It's not about getting more full, which is actually what I think these medications are meant to do.

And they're meant to restore fullness. And in that context, we are looking at sleep disorders. We're looking at lymphedema and lymphedema. We're looking at inflammatory diseases of the liver and the pancreas.

We're looking at inflammatory diseases of the bowel, disruptions of the microbiome. We're actually caring about system that is out of balance often as a result of like the pressures of modern life, but also some genetic stuff.

Whereas and so in the emergency room, I see profound frailty. I did note a shift on Saturday night. Within the first two hours, I had four old ladies with hip fractures needing to go DLR, two hours starting at midnight.

And that's what frailty is. These women are now no longer going to be able to live the life that they they lived before they fractured, because they won't ever be well enough to avoid falls in the future.

One of them was 100. So kudos. But one of them was also like 76. So that's a difference, right? That's a big difference. And then I also see end stage stroke and end stage dementia from vascular risk factors and end stage gangrene from poorly controlled diabetes.

And I see that in thin people too. Right. So this is not just like oh you're thin, you're fine I oh actually no, we, we, we have to pay attention because everything has a potential downstream consequence.

And I think, you know, everyone is is like gunning for true max treatment doses of all of these agents, which I think it's on people is absolutely necessary.

But in a lot of people, what they really need is an appetite guardrail and they need the ability to eat, eat to fullness, experience fullness, know what that is, and then not continue eating deep past that.

And they also and when they are eating deep pasta, they need to be able they need to have a language that says, oh, here's why this is happening. I under fueled earlier today, I didn't treat myself well enough earlier today.

That's why this happened. Or I haven't slept well in a week because my kids are or whatever. Right? That I want

people to have the language of balance when it comes to examining their own lives.

And I think of GP ones as one of those tools that if, if left to to run rabbit, we'll have all sorts of other problem now you can think about like no one studied this, but I think about like constipation is a big problem amongst my medications.

This like all okay. So lots of patients come without treatment and they poop once a week. So they are constipated. Desert. But then they stay sedated.

We work on it, but constipation and then. So chronic conservation leads to, like, diverticulitis. That leads to, like, colitis. It can lead to all sorts of things. Your bowels just don't move.

And then, oh, you have to have half your colon removed. At 65 or 70. And I'm like, well, that's not ideal either. But we're not going to see that data for a decade, multiple decades probably.

So managing hard to patient is something that I check in with my patients every visit because they're all of. But they were constipated before, so it's a hard one to treat you like that's pun in.

Anyway, that's that's a big a big answer to to this this question of like, yeah, we need to be paying a lot of attention. But that means we have to think about these tools, not just as like a magic bullet to her at her.

Yeah.

Long-Term Risks and the Need for Balance

And I think what it raises for me, it's like the things I worry about with this, and I think this is such an important conversation. It's like there's always two different ways to get the same treatment, right.

You can get it the like fast Furious, not followed up with no provider time. Right. I think you can probably mail order a whole bunch of things at this point that I really wish weren't right.

And even I, you know, this is a conversation for another day, but like mail order, hormone replacement therapy, I don't know if that's going to be the silver bullet that we're hoping it is.

I think it's provides incredible access, but I think it also puts this undue responsibility on medication to fix a bunch of things. And it also eliminates some of our opportunities we have when we see patients to have a prevention strategy for all those other things that you're talking about.

Right. Mail order HRT does not prevent you from having a hip fracture. It reduces your relative risk, but it doesn't, protect you. And in the way that I think it, it almost makes it feel like it would and it and I yeah said GLP is I have a similar feeling that like it's going to put pressure on the parts of medicine that we maybe weren't doing that awesome with in the first place, like screening for sarcopenia or muscle loss, helping support like balance and sleep in that period, menopause phase screening for underlying disordered eating regardless of body size.

Like I think that there's a lot like it's like the same things we kind of currently suck at the potential to get sucky or, if we just layer medication on top without the complete strategy, where you actually are addressing all of the things.

And yeah, yeah, if someone's had a lifelong, struggle with weight and we now have like this, I really like my economy of scale, example, but we now have this option for you that, like, allows you to put that back crack down, that has scale that you can access.

And yeah, that you're probably listening and going, like, I'll worry about my muscles later. Right. Like that. That's like the least of your worries in this moment.

But I think if we as always ask ourselves what what our deep desire is with our health, it it usually comes down to

being more functional, not being a, a particular, but esthetic.

Right. Like we you see what we'll get down on the floor with my grandkids. I'm like, well, that's, that's very different that wanting to be the thinnest.

And so I think there is more practitioners like you, that there's more programs like what we're building, that there's more opportunities for people to have a deeper experience with their, metabolic strategy than just getting a prescription, because that's never really solve anything up until this point, even though I think that this is an absolute miracle that we've invented this.

So it's it's and you're like, you're completely right. And it feels like, like, oh, man, if we're going to do this right, it requires such a hands on, high touch experience.

And I believe that in some ways it does. The other side of this is, is weight bias. And like I work for, I advise and direct, a telemedicine platform.

That is, it is it's a, it's mail order medication and a lot of ways. But one of the things that I get to do by being part of scale, is I get to see a lot of cases, like a lot, a lot of large cases.

And so what it allows me to do is to say when someone says, hey, I really want to increase my dose. And I see and the questions we ask them allow me to to screen for this already.

But I see that they have lost already 10% of their body weight in a short period of time. They didn't have a high a very high BMI to begin with. So they were not they were like less than class one obesity.

And they, only eat once a day, which are all questions that we asked them on their renewal. I say, well, I think it's reasonable for you to try eating a couple times a day and see what happens to your intake of really sort of high wanting, high desired foods, ultra processed foods.

Just see what happens. And I bet you'll find that this, this plateau that you feel like you're, you're on is, are actually a plateau. And so by, by reaching a lot of people at scale, I am able to amplify the language that I use in my, in my fact, in our practice.

So I'm able to say it's actually really important you're eating three times a day. If you shut down your appetite further, this is going to actually, paradoxically, make weight gain even more likely.

And also this plateau will become more stable. So, it allows me to reach people with the language of appetite physiology more. And I have to hope that, and of course, like, it's not just a mail order, like, we're we're also building an entire strategy for teaching this.

And normalizing, like, hey, it's okay to be hungry three times a day. It's actually good to be hungry. And this is what that looks like. And, we were normalizing, keeping doses like nice and low and study were normalizing, maintaining a good relationship with your health care provider and keeping track of your blood results.

Like that's the goal as that. So yeah, you can do you can do mail order really incorrectly, I think. But I think that those companies will probably just try and die.

I think that they will not they will fail to maintain a relationship and they will fail to build trust. And that's what's going to happen in any, any space.

My hope is that we can build affordable, accessible and quality at scale using trust. That's that's my goal when it comes to like that sort of met us.

Part of my work. Yeah, I love that. And that's partly why I'm so passionate about what you're building to. I would love, I think you and I could probably talk for I think we've actually proven that we can talk for five days straight

about any topic.

I, I, I would love for you to share, like, how our listeners can find you and also what your closing thoughts are like. What do you want to leave people with?

We went through a lot of things here, like we talked about, we talked about genetics. We talked about emotions. We talked about, you know, the the parts of your brain that drive fueling and appetite.

We talked about how it integrates with the rest of your the way we think about your health. You know, some of those important pillars around supporting appetite that have nothing to do with medication, but then maybe everything to do with medication.

How can our listeners find you? But also like wanting lasting thoughts for, and for our audience. Yeah. My my lasting thoughts are, I must always be kind to yourself.

And if you're if you're a patient, be kind, to yourself. It's really hard. There's a lot of weaponized bias towards ourselves that doesn't serve anyone or anything.

How to Work With Ashley White

And then if you're a provider and you try very hard to invite that compassion into your encounter with the patient because it's it is where you can break down some of those walls, I find it's very helpful.

And then also, this is all gray area stuff. There's a bunch of stuff we don't know. We're all trying to figure it out, but it's very important that we don't throw the baby out with the bathwater on these pretty important molecular advancements.

Then in terms of how you can work with me. So our, our clinic is in Burlington, clearly health burlington.com. And I see patients there in person. And then I also have an online program called the Shift Program.

And it is at, the shift clinic. And the first module of my program is free and freely available. There's lots of useful tools there, including a protein calculator, a fiber calculator.

My basic approach to nutrition, which is very simple, and a couple other tools that you can use to sort of get started. And then, you can follow me on Instagram at Ashley White Dot, MD and that is mostly how you would do. So yeah.

And we'll put the link to all of those things. In the show notes as well. Yeah. We're building on very cool collaborative experience at clarity, which I'm really proud of, which we're also learning a lot.

There, you know, in the, in the six months that we've spent toge working together, we haven't we've barely even told anybody that Ashley, has this incredible, offer, to collaborate with our naturopathic doctors, but also to have a very intensive, experience working with her to achieve, like, this kind of goal, in terms of health.

So we'll put all those links in the show notes. But this is it. This is our party where we're sharing, what's possible. And, I do hope that you go look at the chef de when when Ashley was showing it to me.

On another day, I was like, wait, this is the, like, all of this is available for free. So we would be pleasantly surprised at the number of resources that are available there. So I'd highly encourage that.

You go, and check that out. So thank you so much. Ashford. Like this is just thanks for having read the conversation. And probably, I'm sure, not the last time that we'll be out and chatting through these things, but I hope I gave people enough of that, like pharmacotherapy.

But also there's the like the human side of this discussion, which I actually think is incredibly important. And so

thanks for being here, man. Thanks for having me.

We did it stuck to an hour ish. Yeah. See, thank you for tuning in to Doctor Talks. We hope today's episode has enlightened and inspired you on your path to optimal health.

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